alameda county care connect

An Initiative of Alameda County Health Care Services Agency | A Whole Person Care Pilot

February 2021

Partner Update

Dear Partner,

Welcome to our February Update. In this issue you'll find highlights from our February Steering Committee meeting and updates on activities that support delivery of whole person care in Alameda County.

If you are new to our mailing list and would like to review prior issues, you can find them here. You can also sign up to receive future issues using the link at the bottom of this newsletter.

AC Care Connect Website

Impact of Whole Person Care: Consumer Stories

We open each Steering Committee meeting with a consumer story to keep us grounded around whole person care for our most vulnerable community members.

Gaquayla Lagrone shared the inspirational and powerful story of how she became a Fellow in our Consumer and Family Fellowship Program and now a Peer Advisor with AC Care Connect.

AC Care Connect Peer Advisor Gaquayla Lagrone with her children

Gaquayla explained how she draws on her own experience as a consumer in her work to help consumers access needed resources and services.

As a single mother struggling to find a job and safe, affordable housing for herself and her two children, Gaquayla experienced first-hand the enormous systemic challenges and barriers that so many from under-resourced and underserved communities face. Things began changing for the better when she met Elaine Brown in 2016 and started working at West Oakland Farms. The farm was created through Brown's nonprofit, Oakland & the World Enterprises, with a mission to launch for-profit businesses for ownership by formerly

incarcerated people and other people facing extreme barriers to employment and economic survival.

In 2017, Gaquayla became involved with Building Opportunities for Self-Sufficiency (BOSS) in downtown Oakland and went through their Innovations Program. She then connected with AC Care Connect's Consumer and Family Fellowship Program, led by Valerie Edwards, Director of Clinical Case Management Methods, and Rebecca Alvarado, Manager of Clinical Case Management Projects. After graduating from the Fellowship Program, Gaquayla become a Peer Advisor. She applies her expertise in public health, system navigation and advocacy, family systems, and community sustainability to help others access safe and stable housing, healthcare, and support services for families experiencing loss and separation due to incarceration.

Gaquayla expressed her gratitude for the Fellowship Program, which she stated *"always made me feel like a human being and like I have value. They helped make my life better and now I want to help make others' lives better*." Now, as a Peer Advisor, Gaquayla uses her "*experiences of the past to help build a program for others*" and focuses on *"meeting consumers where they are and helping them overcome disparities*."

For more information on the Consumer and Family Fellowship Program and the Peer Advisors, please see the slides from the February Steering Committee meeting.

Steering Committee Meeting Highlights

Our monthly Steering Committee meetings, coordinated by Liz Taing, AC Care Connect's Planning Director, highlight AC Care Connect program successes and updates. Liz also manages the sustainability planning for AC Care Connect's programs and activities, which was a key focus of the February meeting.

AC Care Connect Planning Director,
Liz Taing, MPH, MSW

CHR/SHIE updates

- **CHR use is increasing steadily and the number of new end-users continues to grow.** To date, 911 people have completed CHR user training and most (67%) are active users of the tool.
- **The number of consumers in the SHIE/CHR is also growing** and increasing the usefulness of the SHIE and CHR. As of the end of January, the SHIE/CHR contained records for 43,682 AC Care Connect eligible consumers and 83,176 "ever eligible" consumers. There were 666,843 consumers in the expanded population.
- **The value of the CHR to users is increasing as more consumers sign ISAs.** As of January 2021, there were 954 consumers with active ISAs which reflects an increase of 126 in January alone. There were another 37 ISAs that had expired for a total of 991 ISAs signed since October 2019. As of early February, consumers can use DocuSign for the ISA instead of manually signing the form. We expect this enhancement to result in more ISAs being signed and that the DocuSign function may help reduce the number of ISAs that expire each year.

Coordination of Care updates. As the number of CHR end-users increases and as more information is available, its value for care coordination increases. Recent expansion of the information in the CHR includes:

- Washington Hospital signed a Data Sharing Authorization (DSA),
- Data integration for Sutter Hospital and St. Rose Hospital is in process, and

- COVID-19 lab test results from the California Reportable Disease Information Exchange system (CalREDIE) have been ingested into the SHIE.

Integration of Behavioral Health and Primary Care. Building on our work with partner organizations over the past year to increase services and supports for people with complex behavioral health challenges, we are engaged in various system initiatives to integrate behavioral health and primary care services. This includes integrating the CHR with the EHR of our federally-qualified health center (FQHC) partners and training behavioral health providers to use the CHR to support care coordination. We are supporting the Alameda Health Consortium's pilot projects to fund Pediatric Care Coordinators to connect pediatric patients who have had Adverse Childhood Experiences (ACEs) to preventive services. Additionally, we are continuing to fund a number of positions to enhance the integration of primary care, mental health, and substance abuse services, including psychiatric consultants to support primary care and behavioral health clinicians and care coordinators to strengthen cross-sector care coordination and utilization.

Sustaining the work of AC Care Connect. Attendees continued the discussion of sustainability planning that has been a focus of recent meetings. The February meeting featured a deeper analysis of our programs and activities with a focus on what our shared impact has been and what activities and programs should be sustained and how. Below we summarize the discussion highlights. Please see the Steering Committee meeting slides for more information.

The discussion focused on three key components of our work:

- **Creating a whole person system of care for unhoused individuals.** Our shared vision of whole person care was realized in the response to the COVID-19 pandemic and the effort to house those at greatest risk at the isolation and quarantine hotels. Over 2,700 households were able to safely isolate/quarantine and/or shelter in place at Roomkey hotels. Sustaining this effort will involve:
    - Coordinated Entry* (a HUD-required process), which was redesigned and is now using a more robust equity-based approach to prioritize people for access to housing services and to offer the most intensive resources to those with the greatest need,
    - Adding more locations as access points for services and housing problem-solving, in addition to already existing Housing Resource Centers (HRCs) and 2-1-1 as primary access points,
    - Making changes to HMIS to achieve more immediate assessment scores and including housing problem-solving services and outcomes, and
    - Designing and implementing new matching procedures for crisis housing and housing navigation.

*HCSA is now the Management Entity for this work, which will be managed through the Office of Homeless Care and Coordination (OHCC)

- **Sustaining cross-sector skills development.** Over the period of July 2018 through January 2021, the Skills Development Unit (SDU) has engaged 1,096 unique participants from 100 unique organizations across 12 sectors through 122 training activities. This helps break down silos and supports care coordination across sectors. We conducted interviews with 13 stakeholders from partner organizations. Interviewees expressed:
    - Strong desire to continue this work due to its impact and the need to strengthen the workforce pipeline,
    - Support for a coordinated system for skills development, and
    - Enthusiastic support for the Onboarding New Hire Academy.

Next steps: A Skills Development Workgroup will be established to help develop and guide a sustained skills development approach.

- **AC Care Connect Consumer and Family Engagement Program.**This Program, designed to further health equity, was created and implemented by Valerie Edwards, Director of Clinical Case Management Methods,and Rebecca Alvarado, Manager of Clinical Case Management Projects. Its vision is to achieve the highest level of wellness for everyone through clinical and social care delivery whenever, wherever, and however it is needed.

Valerie Edwards, LCSW

Rebecca Alvarado, LCSW

- The Program aims to achieve this by:
    - Partnering with other Alameda County agencies and programs to cultivate respectful, engaging collaborations,
    - Facilitating meaningful inclusion of the consumers' and their concerned loved ones' perspectives in planning, processes, and programming,
    - Building a peer workforce trained to further health equity, increase flexibility, and circumvent the complexity of service delivery, and
    - Aligning with system and government priorities and planning (e.g., CalAIM) to ensure the viability and effectiveness of these and other culturally affirmative efforts.

To sustain this Program we are seeking to create a cadre of community health workers (CHWs) who share the lived experience of our consumers including Fellows, Peer Advisors, people on the path of recovery, and youth entering work life. Strategies under consideration for sustaining this work include:

- Housing a training program, developed in partnership with consumers, for CHWs within the County,
- Collaborating with County Human Resources to design job classifications/descriptions to meet CalAIM and other staffing needs,
- Supporting efforts to expand revenue streams to fund CHWs (e.g., through SB803 which allows CHWs to bill Medi-Cal), and
- Conducting an evaluation of the impact of this work to support ongoing improvement.

The Steering Committee will continue this discussion at upcoming meetings and Valerie and Rebecca will provide updates on the work to sustain the Program.

Update on CalAIM Planning

With the State's newly updated release of the CalAIM Proposal, Alameda Alliance for Health, Anthem Blue Cross, and Alameda County Health Care Services Agency (HCSA) have engaged in a collaborative partnership to align efforts related to strategic planning and transitioning to the next iteration of the Medi-Cal program. Both Medi-Cal Managed Care Plans have collaborated on a draft proposed charter and workplan aimed to seamlessly

transition into newly designed Enhanced Care Management (ECM) and In Lieu of Services (ILOS) benefits, the first phase of which begins in January 2022. ECM and ILOS models of care are due to the State by July 2021 and the Medi-Cal Managed Care Plans and HCSA will continue to partner as the CalAIM landscape continues to unfold.

SHIE and CHR Enhancements

Updates from the February Data Governance Committee (DGC) meeting. The DGC is an advisory committee to the Alameda County Health Care Services Agency (HCSA) that provides data governance oversight over the Social Health Information Exchange (SHIE). Members include leaders of partner organizations that provide data feeds and/or are end users of the CHR.

Key highlights of the meeting were:

- **The number of organizations providing data feeds to the SHIE continues to increase**. We now have 32 Data Sharing Agreements (DSAs) with organizations across the spectrum of those providing health, social, housing, behavioral/mental health, SUD treatment, and other services to consumers in Alameda County who are in the AC Care Connect eligible population. Another 19 organizations are in queue including 9 that are in initial discussions and 10 that are reviewing the DSA. Two others are very close to signing the DSA.

- **The DGC members continued the January meeting discussion on whether to permanently expand the population that is viewable in the CHR**—i.e., to include all Medi-Cal and uninsured individuals not just AC Care Connect eligibles. As input to this discussion, Intrepid Ascent, partner of SHIE/CHR technology vendor Thrasys, presented findings of a study that examined how the SHIE compares with other Health Information Exchanges (HIEs) / Health Information Organizations (HIOs) that serve similar populations. Six other HIEs/HIOs—five located in California and one located in New York—were reviewed. The findings were:
    - The SHIE's privacy safeguards are on the stronger side (i.e., more rigorous) in comparison to four of the California HIEs, especially with respect to its auditing procedures. The SHIE was equal in rigors of privacy enforcement to the fifth California HIE with only the New York HIE having more robust central auditing procedures;
    - Further, the SHIE/CHR is continuing to improve its processes and procedures based on input from the DGC and from AC Care Connect program staff;
    - The SHIE has an “extremely stringent approach to consumer data attribution” compared with the other HIEs; and
    - While the SHIE has more robust data access control policies/mechanisms than all but the New York HIE, the SHIE/CHR’s current population of redisclosed individuals is limited compared with other HIEs; only a small number of other HIEs are currently working with non-covered entities or “NCEs” (i.e., non-HIPPA-covered entities) either as a data source and/or a data-viewer. The SHIE/CHR is considered a pioneering organization in its work to include these types of organizations as community partners in data-sharing and moving from a basic HIE to being a Community Information Exchange

(CIE).

The second quarterly CHR end-user survey findings are in!

Sheilani Alix, Data Exchange Unit Operations Director, reported on the recently completed CHR end-user survey. Respondents included CHR users from almost all participating organizations and we are grateful to all who responded. This feedback helps us identify improvements to the CHR and our CHR end-user training and resources.

Sheilani Alix, MPIA, Operations Director Data Exchange Unit

Highlights of the findings are:

- 16.5% response rate (76 of 462 end-users who received the survey),
- Almost 90% of respondents had used the CHR,
- On average respondents rated the CHR 3.9 out of 5 (“very useful”) in terms of its usefulness as a tool for care coordination,
- 73% of respondents found the data expansion to be helpful when locating clients/consumers, and
- Respondents expressed a desire to have more data in the CHR (e.g., medications, labs, discharge summaries) and more post-training support.

Several respondents commented on the usefulness of the tool including:

- *Excited to see this product continue to evolve!*
- *This has been a great resource for integrated care. The alerts have been the most helpful. I have contacted case managers and other providers who were not aware that a client was brought to the ER.*
- *CHR is another tool in my toolbox.*
- *CHR is easy to use.*

Next Steps: We are currently identifying and prioritizing needed improvements and will share our plans in upcoming communications.

For more information on AC Care Connect click here.

Kathleen A. Clanon, MD

Thank you for your ongoing dedication and support of Care Connect, Alameda County's Whole Person Care initiative. Please feel free to share this newsletter by forwarding to friends and colleagues.

Your partner in connecting consumers for better health,

Kathleen A. Clanon, MD
Director, Alameda County Care Connect and Medical Director
Alameda County Health Care Services Agency

Did you receive the *Partner Update* from a colleague? Click here to join our mailing list.

AC Care Connect Steering Committee Members

Aaron Chapman, Alameda County Behavioral Health Care Services | **Kathleen Clanon, M.D.,** Alameda County Care Connect | **Scott Coffin**, Alameda Alliance for Health | **Lori Cox**, Alameda County Social Services Agency |**Elaine de Coligny**, Everyone Home | **James Jackson**, Alameda Health System | **Colleen Chawla**, Health Care Services Agency | **Beau Hennemann**, Anthem | **John Jones III**, East Oakland Black Cultural Zone and Just Cities | **Karl Sporer, M.D.,** Alameda County Emergency Medical Services | **Wendy Peterson**, Senior Services Coalition | **Ralph Silber**, Alameda Health Consortium | **Wendy Still**, Alameda County Probation | **Michelle Starratt**, Housing and Community Development

www.accareconnect.org